

PEDIATRIC HEALTH QUESTIONNAIRE

BIRTH HISTORY

CHILD'S BIRTH WEIGHT: _____ DURATION OF PREGNANCY: _____
MOM'S AGE: _____ DAD'S AGE: _____ ANY PROBLEMS WITH PREGNANCY? Y N
TYPE OF DELIVERY: _____ IF YES, SPECIFY _____
PLACE OF DELIVERY: _____
ANY MEDICATIONS, SMOKING, DRUGS DURING PREGNANCY? Y N
ANY PROBLEMS WITH LABOR/DELIVERY? Y N IF YES, SPECIFY _____
LENGTH OF STAY IN NURSERY: _____

MEDICAL INFORMATION REGARDING PATIENT

ANY HISTORY OF COLIC OR UNUSUAL FEEDING PROBLEMS BEFORE 3 MONTHS? Y N
ANY MINOR ILLNESS ABOUT WHICH YOU WORRY? Y N HAD CHICKENPOX? Y N
HAS YOUR CHILD HAD MORE THAN 4 BOUTS OF EAR INFECTIONS IN ONE YEAR? Y N
ANY MAJOR ILLNESS / HOSPITALIZATION? Y N IF YES, SPECIFY _____

ANY SURGERY? Y N IF YES, SPECIFY _____

ANY ACCIDENTS / INJURIES? Y N IF YES, SPECIFY _____

ANY MEDICATIONS TAKEN REGULARLY? Y N IF YES, SPECIFY _____
ANY KNOWN DRUG ALLERGIES? Y N IF YES, SPECIFY _____

DEVELOPMENTAL HISTORY

DO YOU THINK YOUR CHILD IS UP TO DATE WITH PEERS? YES NO
CURRENT SCHOOL GRADE: _____ SPECIAL CLASSES? YES NO
PERFORMANCE IN SCHOOL, STRENGTHS _____
WEAKNESSES _____

FAMILY HISTORY: INCLUDE ONLY CHILD'S PARENTS AND SIBLINGS

HIGH CHOLESTEROL / HEART DISEASE / HIGH BLOOD PRESSURE	DIABETES	CANCER
ALLERGIES / ASTHMA / ECZEMA	ARTHRITIS	ADD/ADHD
KIDNEY DISEASE/URINARY TRACT INFECTIONS	SEIZURE	THYROID
IRRITABLE/INFLAMMATORY BOWEL DISEASE	MIGRAINES	ANEMIA
LAZY EYE/VISION PROBLEMS	OTHER: _____	
HEARING LOSS		

SOCIAL HISTORY

NUMBER OF PEOPLE IN HOUSEHOLD: _____ ANY SMOKING? YES NO
NAMES & AGES OF SIBLINGS: _____
